

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES**

**OVHA**

**Office of Vermont Health Access**

**Bulletin NO: 06-05F**

**FROM:** Joshua Slen, Director  
Office of Vermont Health Access

**DATE:** 6/15/2007

**SUBJECT:** Global Commitment to Health Grievance And Appeal Rules

**CHANGES ADOPTED EFFECTIVE 7/1/2007**

**INSTRUCTIONS**

**Maintain Manual - See instructions below.**  
 **Proposed Regulation - Retain bulletin  
and attachments until you receive  
Manual Maintenance Bulletin: \_\_\_\_\_**  
 **Information or Instructions - Retain  
until \_\_\_\_\_**

**MANUAL REFERENCE(S):**

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This bulletin implements the rules for the grievance and appeal procedure required under the federally approved Global Commitment to Health 1115(a) waiver program. The federal regulations published at 42 C.F.R. Part 438 govern the provision of Medicaid services through managed care. The Office of Vermont Health Access, as a Managed Care Organization (MCO) under the Global Commitment 1115(a) waiver, is required under Part 438, Subpart F, to have an internal grievance and appeal process that complies with federal rules for resolving service disagreements between beneficiaries and MCO employees, representatives of the MCO, and state designated agencies. Beneficiaries (or designated representatives) may file grievances or appeals orally or in writing. The overall goals of the grievance and appeal process are to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of MCO staff decisions concerning appealable actions.

OVHA has interagency agreements with Agency of Human Services departments for services that are provided as part of the MCO within the framework of the Global Commitment. Consequently, services that are administered or provided by those departments pursuant to the terms of the agreements are MCO services and beneficiaries of those programs have access to the MCO grievance and appeal process. These interagency agreements are not a part of this or any other bulletin.

The rules include a level of review by those not involved in the decision grieved or appealed. Resolutions of grievances and appeals will be clearly communicated to the beneficiary and his/her representative.

There are specified time frames for resolving grievances and appeals at the MCO level. In addition, MCO beneficiaries are entitled under federal regulation to certain protections with respect to grievances and appeals, and may appeal using the State fair hearing process. The availability of these safeguards should not be construed to preclude an optional reconsideration of a decision by an MCO staff member who made the original decision. A request for reconsideration may be made by a provider, the beneficiary or the representative of the beneficiary. A request may be accompanied by additional information that supplements or clarifies material that was previously submitted and is likely to materially affect the decision.

The processes described in this section apply to Medicaid, pharmacy programs, VHAP, and the beneficiaries financed through the State Child Health Insurance Program (SCHIP), although SCHIP is not part of the Global Commitment waiver.

***Specific Changes to Rule Sections Since the Last Filing***

<b>Section</b>	<b>Description of Change</b>
Entire Rule	The Effective Date was changed from June 1 to July 1, 2007 to allow more time to review and consider comments.  The sections were renumbered and reorganized for clarification and to make the rules flow logically. Unless otherwise stated, the section numbers referenced in these descriptions are the updated numbers.
M142	The appeal process is now optional.
M143	The language for recovery of continuing benefits paid during the appeal/fair hearing period was revised to agree with corresponding language in section M181.3 D.
M180.1 A	The phrase “state agency” at #4 was removed to agree with corresponding language in section M181.2.  The definition of “action” is clarified to indicate that these occurrences may be subject to an appeal.  Sections 6 (a), (b), (c) and (d) were removed to simplify the definition.
M180.1 B	The definition of “appeal” is clarified to indicate that it is internal.
M180.1 G	The definition of “grievance” is clarified by including federal language and adding two particular situations.

M180.1 I	The last sentence of the definition of “Network” was deleted. Any enrolled provider is part of the network.
M181	<p>The language in former section M180.5 F dealing with M108 appeals was moved to section M181 B.</p> <p>Language was added to section M181 A to allow a beneficiary to request a fair hearing if the initial MCO decision was based solely on an issue of rule or law.</p> <p>The Request for Reconsideration section was removed and pertinent language explaining such requests was added to section M181 A.</p> <p>The thirty-day limitation for requesting a reconsideration was removed to permit more flexibility for those beneficiaries considering an appeal.</p> <p>Exhaustion was eliminated as the appeal is now optional.</p>
M181 A	<p>Language automatically classifying eligibility and premium determination appeal requests as fair hearing requests was added.</p> <p>The paragraph stating that MCO actions are considered preliminary decisions subject to appeal is deleted as no longer necessary.</p>
M181 C	The word “financial” was deleted to allow for all eligibility factors.
M181 E	Language was added that details the process for a beneficiary to obtain policy and medical record information from the MCO.
M181 F	Language conforming with 42 C.F.R. § 438.406 (b)(3)(ii) was added to further define the who will be reviewing internal appeals.
M181.1	Notice language was revised to agree with the requirements of 42 C.F.R. § 438.410(c).
M181.3 B	<p>The paragraph was deleted that allows certain agencies to continue services at their discretion without being requested to do so.</p> <p>In section (2), the language requiring continuation of services until “any applicable annual treatment plan has expired” was deleted.</p> <p>Language was added to item 2(b) to clarify limits as stated in law or rule.</p> <p>Items #4 in the first section and #5 in the second section were deleted because they are duplicative: an annual plan of care or an annual treatment plan are considered “services” already contemplated under #5 in the first section and #6 in the second section.</p>

M181.3 D	The language for recovery of continuing benefits paid during the appeal/fair hearing period was revised to agree with corresponding language in section M143.
M182	The appeal process is now optional.
M184	For simplification, there is no longer a distinction between a formal and an informal grievance.
M184.4	To avoid confusion when disposing of grievances, the time frame for disposition was extended to 90 days from 60, thereby relieving either party from requesting an extension.  The sentence regarding appeals to the Human Services Board was deleted and the topic moved to M184.5 C.
M184.5 C	Language was added to clarify the relationship of grievances and the Human Services Board.
3204.5	The appeal process is now optional.
3302.6	The word “denied” was added as an action to a service that would require notice and would create a right to request an internal MCO appeal.  The appeal process is now optional.
3402.8	The word “denied” was added as an action to a service that would require notice and would create a right to request an internal MCO appeal.  The appeal process is now optional.
3504.3	The word “denied” was added as an action to a service that would require notice and would create a right to request an internal MCO appeal.  The appeal process is now optional.
4002.6	The word “denied” was added as an action to a service that would require notice and would create a right to request an internal MCO appeal.  The appeal process is now optional.

***Responses to Public Comments***

A public hearing was held on January 4, 2007 from 3:00 to 6:00 p.m. at the Central Vermont Medical Center boardroom, Berlin, Vermont. Comments were received at the hearing from Carolyn Jarrett, Staff Attorney for Senior Citizens Law Project, and Betsy Blackshaw, private practice attorney.

OVHA received written comments from the Office of Health Care Ombudsman, Vermont Ombudsman Project, Vermont Coalition for Disability Rights, Senior Citizens Law Project and Voices for Vermont's Children.

Their comments are summarized below along with OVHA’s responses.

**Comment:** A commenter stated that the proposed regulations create an appeals and grievance system that is unnecessarily complex and administratively burdensome.

**Response:** The proposed rules are modeled after the system mandated by the Federal Medicaid regulations at 42 C.F.R. 438, Subpart F. A streamlined grievance process was created by the elimination of the distinction between formal and informal grievances. A request for reconsideration is now unmistakably identified as an informal and optional course of action. A selective reorganization of the rules has produced a logical guide to the appeals and grievance process. The reorganization included renumbering the sections to clearly delineate the separate processes. In order to avoid confusion, all references to section numbers in these responses refer to the original section numbers quoted in the received comments, not the reorganized numbers. All correspondence from OVHA will clearly inform beneficiaries of their options and how to proceed or obtain assistance if they wish to pursue such options.

**Comment:** OVHA already reviews decisions internally, using staff and the Commissioner Review process, when a fair hearing is requested. OVHA may simply have to make some modifications to its current internal reviews to bring it into compliance with the federal Medicaid regulations.

**Response:** The only review currently done by OVHA is a random procedural review performed by non-clinical staff. OVHA does not use a Commissioner Review process. The proposed rules modify the current process to conform with federal regulations and require a clinical review by a different, impartial clinician.

**Comment:** The proposed regulations do not comply with state law on access to fair hearings or with the fair hearing regulations.

**Response:** The proposed rules are in full compliance with both state and federal law. Federal regulations grant an appeal and, if necessary, a subsequent fair hearing based only on a defined *action* by the MCO. This definition of *action* at 42 C.F.R. § 438.400(b) includes an occurrence that terminates, suspends or reduces covered services, the MCO fails to act promptly, or a claim for services is denied. This federal definition of an *action* is paralleled in the proposed rules and state law at 3 V.S.A. § 3091(a).

**Comment:** The proposed regulations narrow beneficiaries' due process rights for appealing MCO decisions.

**Response:** The proposed rules do not preclude a beneficiary from accessing the fair hearing process. 3 V.S.A. § 3091(a) requires that an opportunity for a fair hearing be granted upon an action that denies or affects a beneficiary's "assistance, benefits, or services." That opportunity is not being revoked. The proposed rules simply require that the action by OVHA is a complete, final and informed decision before it can be adjudicated at the fair hearing level. OVHA will remain in compliance with the Human Services Board Rules as quoted in the All Program Procedures at P-2127(F)(1) by providing assistance to any person that expresses a clear indication (oral or written) that that person wishes to submit a request for fair hearing.

*NOTE: Following discussions with advocates and the Legislative Committee on Administrative Rules, we have changed the rule to make appeals optional, thus mooted this issue.*

**Comment:** Requiring exhaustion of an internal MCO review before allowing a beneficiary to request a review through a fair hearing will create significant delays to a beneficiary's access to fair hearings.

**Response:** The internal MCO appeal process will result in more timely decisions for the beneficiary. According to current statistics, only 2.4% of fair hearings since 2000 have resulted in a reversal of OVHA's decision. This number is expected to be reduced upon implementation of the MCO internal appeal process. Based on these statistics, the MCO internal appeal process will result in a more timely decision for at least 97.6% of appealing beneficiaries. Under the MCO internal appeal process, any case that is appealed will undergo a thorough procedural and clinical review and will immediately consider new information to ensure that the correct decision had been made. In the majority of cases this process will take no longer than 30-45 days. For a fair hearing, it currently takes three to five weeks to be scheduled due to the volume of cases. Additionally, fair hearings are typically continued month to month if additional information is supplied by the beneficiary or if a beneficiary believes that they can obtain further information. In many cases, this additional information is what allows OVHA to issue an approval for the requested service. This discussion and receipt of this information will happen much more quickly through the internal appeal process. Requiring exhaustion will reduce the number of cases that need to be addressed at fair hearing and therefore will allow for a more timely resolution of those cases by the Human Services Board.

*See NOTE on page 5.*

**Comment:** The federal regulations do not require that beneficiaries exhaust MCO internal appeals before filing a fair hearing request.

**Response:** 42 C.F.R. § 438.402(b)(2)(ii) provides that a state has the option to require exhaustion of MCO level appeals prior to requesting a fair hearing. OVHA endorses exhaustion of the MCO internal appeal process because: 1) decisions will be made more timely than at fair hearing; 2) reviewing decisions at the MCO level will improve clinical decision-making across the MCO by ensuring review by senior clinical staff; 3) exhaustion will reduce the Human Services Board workload and expenditure of its resources and will thereby result in timelier fair hearing decisions; 4) current Medicaid managed care rules at M103.2E require exhaustion of internal managed care plan appeals prior to requesting a fair hearing; 5) under 8 V.S.A. § 4089f and BISHCA Regulation H-99-1, beneficiaries enrolled in private MCOs are required to exhaust all internal review procedures before having the right to an independent external review (in fact, out of the 41 states that do have independent external reviews of MCO decisions, all but one state requires exhaustion of internal remedies); 6) exhaustion is consistent with current practice within AHS as several AHS departments have provisions for "Commissioner" reviews of contested decisions. Often the HSB will not hear a case, or will remand a case to the department for a Commissioner review, prior to a final HSB decision; and 7) the internal MCO appeal provides the beneficiary a formal opportunity to engage in dialogue with departmental representatives, not the department's attorney, who will consider new information supplied by the beneficiary or his/her provider.

*See NOTE on page 5.*

**Comment:** While commercial managed care organizations must have internal appeals processes pursuant to Vermont's Rule 10, the time frames that individuals have to request appeals, and the timeframes that insurers have to decide appeals are far different than those proposed in these regulations.

**Response:** Under Global Commitment and 33 V.S.A. § 1901 (d)(2), the OVHA as an MCO is not subject to Rule 10. The rules as proposed are consistent with the governing federal regulations. Under Vermont’s Rule 10, however, an appeal related to medical care must be resolved 15 days after receipt of the information necessary to resolve the appeal. There is no time limitation for a determination of when that information must be received or when it is decided whether what has been received constitutes the “information necessary.” The timeframe under Rule 10 can therefore extend far beyond the 45 days set forth in the proposed rule.

**Comment:** The safeguard of requiring a clinical peer participating in the internal review is meaningless since state government has limited clinicians on staff.

**Response:** Federal regulations at 42 C.F.R. § 438.406(a)(3) require that individuals who make decisions on appeals are individuals who were not involved in any previous level of review and have the appropriate clinical expertise. The MCO must comply with these regulations and, if necessary, will resource this process accordingly.

**Comment:** The appeals process as proposed will likely violate federal Medicaid law regarding “final administrative action.” It is unrealistic to think that the state can meet the federal requirement of final administrative action within 90 days under the proposed process.

**Response:** 42 C.F.R. § 431.244(f)(1) requires the state to take final administrative action within 90 days from the date the enrollee filed an MCO appeal, not including the number of days the beneficiary took to subsequently file for a state fair hearing. We interpret this to mean that the amount of time elapsed between the filing of an MCO appeal and a request for a fair hearing does not count toward the 90 day requirement to take final administrative action. If a beneficiary does not request a fair hearing, under the proposed rules, an MCO appeal decision would have been issued within 59 days. If a fair hearing is subsequently requested, final administrative action must be taken within 90 days.

NOTE: With the change to make the appeal optional, this is no longer an issue.

**Comment:** The terminology used is confusing. Beneficiaries and advocates have referred to fair hearings as “appeals” for years. To now call an internal review an “appeal” will be confusing. The request for review to the MCO should be called an “internal review”.

**Response:** The language and terminology used in the proposed rules is consistent with the language and terminology used in the federal regulations. 42 C.F.R. § 438.400(b)(6) defines an appeal as “...a request for review of an action...”

**Comment:** The regulations at M142 refer to the date of mailing of notices as the operative date for determining appeal time frames. OVHA notices do not have mailing dates on them, and haven’t for some time.

**Response:** The date of the notice is considered the mailing date. 42 C.F.R. § 438.402(b)(2) dictates that “The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO’s notice of action. Within that timeframe-(i) the enrollee or the provider may file an appeal.” OVHA currently allows the full 90 days to request an appeal.

**Comment:** The language regarding recovery of continued benefits is internally inconsistent between M143 and M180.5 (D).

**Response:** We agree. The language has been revised in both sections so it is identical and in agreement with 42 C.F.R. § 431.230-231 and 42 C.F.R. § 438.420.

**Comment:** The federal regulations were written with commercial managed care organizations in mind, not state Medicaid agencies acting as MCOs. A network is not a concept that transfers easily from commercial insurance to the Medicaid context.

**Response:** We believe that the concept of a network transfers very well from commercial insurance to the Medicaid context. In order to clarify the definition and make sure that the concept more clearly transfers, the second sentence of the definition of “network” at 180.1(I) was deleted. Also, in the definition of “action” at 180.1(A), sections 6a, b, c, and d were removed to avoid confusion. Those sections were not related to the definition of action and could have unintentionally been construed to limit an “action” to only those circumstances.

**Comment:** Section M180.1(A)(4) is inconsistent with M180.4.

**Response:** We agree. The words “state agency, or” have been removed from M180.1 (A)(4).

**Comment:** At 180.1(H), it is not clear why the Department of Education is excluded from being part of the MCO when it has an intergovernmental agreement with OVHA, and Medicaid services are provided by the Department under Global Commitment. Is the intent to list all departments and divisions providing services under the Global Commitment? If so, are the ones listed all of them? What about Office of Drug Abuse Prevention and other parts of the Department of Health?

**Response:** As explained at M180.6, the Department of Education uses its own appeal procedures. To qualify for reimbursement, such services must be included in the child’s IEP (individualized education program). Any question of inclusion under an IEP must be appealed using the Individuals with Disabilities Education Improvement Act (“IDEA”) statutes and is outside the scope of OVHA jurisdiction. The intent was not to list all of the departments and divisions providing services under Global Commitment because a rule change would then be necessary every time a department changed its name or reorganized. The listed departments serve merely as examples of departments that would be included under the definition and are not exhaustive.

**Comment:** The definition of “service” at M180.1 (K)(3) should include benefits *authorized by federal regulation* as well as state rule or law.

**Response:** The language recommended by the commenter would not be accurate because it would suggest that the state covers all optional services authorized by federal regulations. Those services that are covered are detailed in the documents named in the definition.

**Comment:** It is not clear from its definition in M180.2 (A) how a request for reconsideration is distinguishable from a grievance. It should be eliminated. This additional formal step makes the process too complicated. OVHA is creating too many layers of review, which will discourage

beneficiaries from exercising their due process rights. If adopted, however, reconsideration decisions should be in writing.

**Response:** We agree that the steps can be simplified to be less confusing. The request for reconsideration section was an effort to formalize an informal process that has always been available to a beneficiary. Section M180.2 (A) was removed to simplify the appeal process. A clear description of the option to request a reconsideration is now included as part of the introductory language at M180.2. To further simplify the process, the time frame limitation for requesting a reconsideration has also been removed.

**Comment:** M180.2 (A) provides that the request for reconsideration needs to be made within 30 days of the notice of decision, does not suspend the 90 day time frame for filing an appeal, and is not considered an appeal. We believe that codifying and limiting the time frame of this process is completely unnecessary, in that a person should always be able to ask a worker to re-look at an erroneous decision. Additionally, it is not clear how a worker will determine whether a statement by an individual that s/he is unhappy with a decision is a request for reconsideration, or is a request for an internal review.

**Response:** We agree that there should be no time limitation for requesting reconsideration of an MCO decision. The time frame limitation for requesting reconsideration has been removed. Since 42 C.F.R. § 438.402(b)(2), limits the time frame for filing an appeal at 90 days, the time frame for reconsideration was intended to provide beneficiaries a sufficient amount of time after the reconsideration decision to file an appeal. The rule now illustrates that a reconsideration is not part of the appeal process.

**Comment:** Why are MCO actions considered “preliminary decisions” at M180.2?

**Response:** An MCO action is not considered a final administrative action until it is no longer subject to appeal: 90 days from the date of the MCO notice of action.

NOTE: Making appeals optional means that this language is no longer necessary so it has been deleted.

**Comment:** In some cases it is clear that the denial of a given service is based on policy interpretation rather than clinical information. In that case, an internal appeal will be useless to the beneficiary, because the agency will merely reaffirm its policy position. It will be necessary to go to the fair hearing process to have an independent review of this type of agency decision.

**Response:** We agree that an appeal is inappropriate in these situations. Language was added to M180.2 that states: “When a benefit is denied, reduced, or eliminated as mandated by federal or state law or rule, the beneficiary is not required to appeal the decision through the MCO appeal process. The beneficiary may challenge the decision by requesting a fair hearing.”

NOTE: This language was later modified to be clear that appeals are not available in these circumstances.

**Comment:** Appeals of financial eligibility or premium determinations mistakenly filed with the MCO under M180.2 (B) must be considered a request for fair hearing as of the date the MCO receives it. The regulations should state this.

**Response:** We agree. Appropriate language has been added to this section.

**Comment:** The proposed regulation at M180.2 (C) requires a “clear determination that third-party involvement is being initiated at the beneficiary’s request” in situations where providers or representatives initiate internal reviews. Please clarify why this requirement is included, what is meant by a “clear determination”, who will make that determination, what criteria will be used, etc.

**Response:** This requirement was included to protect the confidentiality of a beneficiary’s private health information. A “clear determination” is an affirmative statement that the beneficiary is requesting third party representation. This clear determination policy is the current practice and is used when a beneficiary requests third party involvement in a fair hearing and will remain consistent under the new MCO appeal rules.

**Comment:** The federal regulations require that beneficiaries be given any “reasonable assistance” in filing appeals, including providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. 42 C.F.R. Section 438.406(a)(a). The regulations should include language about this assistance being available, and ensure that it is available.

**Response:** OVHA is required to comply with all such federal regulations. Although it is not necessary to duplicate every applicable federal regulation in this rule, M180.2 (C) does state that assistance will be provided to the beneficiary to initiate and participate in the appeal.

**Comment:** The regulations at M180.2 (D) say that if the issue is “resolved” within the five day time frame, only one notice will be sent. How is OVHA defining “resolved”? Only when the original decision is reversed should the review be considered resolved from the beneficiary’s point of view. Approval of a different service or one limited in scope or authorization should not be considered as a “resolved” appeal.

**Response:** The statement was intended as a procedural clarification, but instead has apparently caused confusion. In order to simplify, the statement has been removed from M180.2 (D). Acknowledgment of receipt is implicit if a notice of decision is being issued.

**Comment:** Standards for sharing file information with the appellant quickly and for gathering any additional information needed for the review should also be spelled out more fully in the regulations.

**Response:** We agree that a beneficiary appealing an MCO decision should have full access to all relevant information in order to facilitate a more complete review and subsequent decision. The following language detailing access to beneficiary medical records has been added to M180.2 (F): “Upon request, the MCO shall provide the beneficiary or their representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The department will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.”

**Comment:** The regulations for how internal review requests will be handled when filed with the wrong entity within state government raises concerns about requests being lost in the shuffle among

state agencies with the possibility that there may be disagreement within the MCO over which agency or department will assume responsibility for the internal review.

**Response:** The entity issuing the initial notice of action will be the entity handling the appeal. Responsibility will be clear and will leave no chance for disagreement.

**Comment:** It is unclear how the MCO will be deciding internal appeals in M180.2 (G). Much more detail needs to be provided and written into regulation to make the internal review meaningful. It is good that subordinates of the original decision maker will not be allowed to make review decisions, but what about staff of equal status to the original decision maker? How likely is that to result in a fair unbiased review of the request for coverage? What standards will the reviewer(s) use in deciding whether the original decision should be reversed?

**Response:** Federal regulations do not prohibit peers from reviewing the decisions of the original decision maker. Each entity will establish their own processes for ensuring that the independent review complies with federal regulations and is free from bias. Each case will be individually evaluated on the merits using applicable policy, medical necessity, and the information provided as a basis for the decision. Language conforming with 42 C.F.R. § 438.406 (b)(3)(ii) was added to further define who will be reviewing internal appeals.

**Comment:** The regulations at M180.2 (H) allow for decisions to be made in internal reviews without a meeting with the beneficiary, representative, or provider.

**Response:** The rules are designed to oblige the schedules of the beneficiary, provider, and/or representative and allow them to attend the meeting where the appeal decision will be made. Every effort will be made to accommodate the parties involved, but federal regulations at 42 C.F.R. § 438.408 (b) and (c) mandate that a decision be issued within 59 days.

**Comment:** It is not clear why the MCO needs 45 days to make a decision. Under these rules, the MCO can give itself an additional 14 days if it determines this extension is in the best interest of the beneficiary, bringing the total to 59 days. Since the state is reviewing its own decision, a review should happen more quickly. Information OVHA gave the Medicaid Advisory Board in October 2006 stated that if a case is going to be reversed, it usually occurs within one or two weeks of receipt of the Fair Hearing request. Commercial managed care organizations have 30 days to make an internal review decision in most situations where individuals are waiting for care.

**Response:** As in the previous response, the timelines are designed to oblige the schedules of the beneficiary, provider, and/or representative and allow them to attend the meeting where the appeal decision will be made. A restriction of this determination period would result in less beneficiaries being represented at the appeal meeting. The current schedule also allows more time for the parties to provide information that would permit the MCO to reverse its initial decision. The MCO will make a decision after the meeting (and/or all additional information is submitted) which may be sooner than the 59 days. The MCO will not as a rule wait the 59 days-it is a maximum time frame only. As stated previously, the current internal reviews are cursory non-clinical reviews and do not consider additional information submitted by the beneficiary.

**Comment:** The regulations should clarify how the MCO will decide and what criteria it will use when deciding whether it is in the beneficiary's best interest to extend the decision making period. On

its face, this seems to undermine the very purpose of an internal review, and could add significant delay to obtaining needed medical care.

**Response:** It will be in the beneficiary's best interest to permit an extension of the decision making period when, for example, necessary to accommodate the schedule of a beneficiary, provider, and/or representative or to allow the submission of additional information.

**Comment:** Please clarify why a denial of a request to process an appeal as expedited at M180.3 must be mailed within two working days but must be communicated orally within three working days. If the beneficiary has requested an expedited appeal, and the request is denied, the beneficiary should be told orally immediately, with written notice to follow.

**Response:** We agree. The wording of the current rule was confusing and was revised to clearly require prompt oral notice and written notice within two calendar days thereafter in compliance with 42 C.F.R. § 438.410 (c) (2).

**Comment:** The regulations should be clarified so it is clear that when a beneficiary requests continuing benefits upon filing a request for an internal review, the benefits will continue if the beneficiary subsequently requests a fair hearing. Beneficiaries should not be required to request continuing benefits twice.

**Response:** The rules do not require a beneficiary to request continuing benefits twice. M180.5 (B) currently states that "a service must be continued until any one of the following occurs: 3) The MCO issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame."

**Comment:** At M180.5 (B), why are only certain named agencies allowed to continue benefits at their discretion, even though no interested party has timely requested them? This seems inconsistent with other provisions of the regulations requiring clear determinations that a third party is acting on a beneficiary's behalf and the regulations regarding recovery of services pending appeal. Please clarify.

**Response:** We agree that it would be inconsistent to grant certain agencies the discretion to unilaterally continue benefits and have therefore removed the language at M180.5 (B) granting such privileges.

**Comment:** The state is narrowing the situations in which beneficiaries are allowed to receive continued benefits pending an appeal at M180.5 (B). The purpose of these regulations is to allow for a meaningful internal review of MCO decisions, and not an opportunity to narrow beneficiaries' rights to continuing benefits. For example, #2 in the second numbered section states that benefits will continue until "any limits on the cost, scope or level of service have been reached". What if the scope or level of service is the subject of the appeal? #4 in the first numbered section states that benefits can continue if "any applicable annual plan of care has not expired at the time the appeal is filed." #5 states that benefits can continue until "any applicable annual treatment plan has expired." #6 states that benefits will continue until "the original service period ordered by an authorized provider has expired". Why are these new limitations on the receipt of continuing benefits part of the proposed regulations?

**Response:** The rules are clarifying both the instances when a beneficiary must be granted continuation of services and narrowly defining when benefits must be discontinued. The referenced #2 represents those limits as set forth in law or rule. Language has been added to clarify this. The language at #6 is taken from the federal regulations at 42 C.F.R. § 438.420 (c)(4). We have decided to delete #4 in the first section and #5 in the second section because they are duplicative: an annual plan of care or an annual treatment plan are considered “services” contemplated under #5 in the first section and #6 in the second section.

**Comment:** Section M180.5 (B) should be re-numbered, since there are two M180.5 (B) (1), (2), (3), (4) and (5)’s.

**Response:** We agree. The section has been re-numbered to differentiate.

**Comment:** The process being proposed for filing grievances is far too complicated and doesn’t make sense. This section needs to be completely reworked to make it a simple, clear grievance process with clear timeframes for filing grievances and for the MCO making grievance decisions, with an explanation of the process the MCO will use for deciding grievances.

**Response:** A streamlined grievance process was created by the elimination of the distinction between formal and informal grievances and making the process a flat 90 days, thus significantly simplifying the process. Also, portions of the grievance section were removed as they were more appropriate as internal procedures rather than rules.

**Comment:** State law requires that beneficiaries be allowed to file Fair Hearing requests about any agency action affecting receipt of benefits or services or if the individual is aggrieved by agency policy as it affects his or her situation. The proposed regulations stating that grievance decisions are not appealable to the Human Services Board violate state law.

**Response:** The proposed rules are in full compliance with both state and federal law. Neither state nor federal law permits a beneficiary to file a fair hearing for a grievance. Neither state nor federal law permits a beneficiary to file a fair hearing for a grievance. Federal regulations at 42 C.F.R. § 438.408 (e) grant an appeal and, if necessary, a subsequent fair hearing based only on a defined *action* by the MCO. This definition of *action* at 42 C.F.R. § 438.400 (b) includes an occurrence that terminates, suspends or reduces covered services, the MCO fails to act promptly, or a claim for services is denied. This federal definition of an *action* is paralleled in the proposed rules and state law at 3 V.S.A. § 3091(a). A grievance is defined at 42 C.F.R. § 438.400 (b) as “dissatisfaction about any matter other than an *action*.” Because it does not satisfy the criteria of state law or federal regulations and is expressly excluded from the definition of an *action*, a grievance is therefore not eligible to be heard at fair hearing. Furthermore, the language at 3 V.S.A. § 3091(a) states that a fair hearing can be requested when an “individual is aggrieved by agency policy.” This corresponds to the revised language at M181, where the beneficiary may go directly to fair hearing for issues of state or federal law or rule.

**Comment:** The regulations governing the right to appeal for all four pharmacy programs should be consistent across all four programs. As written, they are not. The regulations for the pharmacy programs need to be clear that appeals of decisions regarding eligibility do not go through the MCO process but directly to fair hearing.

- Response:** The language for the pharmacy programs is consistent in regard to both eligibility and coverage appeals. Eligibility issues are clearly directed to the fair hearing process while coverage issues are referred to the internal MCO appeal process.
- Comment:** The regulations make changes to the Beneficiary Fraud regulations for VHAP Pharmacy and VPharm, but not VScript.
- Response:** There were no changes made to the Beneficiary Fraud section of the VPharm rules other than relocating that section to a new page. The only alteration to the VPharm Beneficiary Fraud section was to replace the outdated name “PATH” with “ESD.”
- Comment:** Pharmacy program beneficiaries who waive their right to continuing benefits pending review should be reimbursed if a subsequent decision reverses the OVHA/MCO decision. Currently, the regulations allow for reimbursement when the MCO or the Human Services Board reverses the decision.
- Response:** OVHA is the MCO. Therefore, since the regulations allow for reimbursement when the MCO or HSB reverses the decision, beneficiaries are reimbursed if a subsequent decision reverses the original “OVHA/MCO” decision.
- Comment:** The regulations at 4002.6 need to state that applicants and beneficiaries who are denied benefits have the right to appeal, not only when benefits and eligibility are reduced or discontinued.
- Response:** We agree. The word “denied” was added to the words “reduced” and “discontinued” at sections 3302.6, 3402.8, 3504.3, and 4002.6.
- Comment:** The proposed rule allows the state to recover the cost of continuing benefits if a recipient loses the appeal. This provision is not in the existing rule. Recovery of continuing benefits paid pending appeal is allowed, but not required, under Medicaid law. 42 U.S.C.A. § 1396p (a)(1)(A); 42C.F.R. § 433.36(g)(1). However, it has never been the department’s practice to recover these incorrect payments. If the department intends to change its practice, it should explain how it intends to collect this debt and how it intends to comply with federal Medicaid law governing this type of recovery.
- Response:** The state currently does have the right, under certain circumstances at M143, to recover the cost of continuing benefits during an appeal when a beneficiary loses the appeal. Upon a decision in favor of the state, OVHA’s policy, as permitted by 42 C.F.R. §§ 431.230 (b) and 438.420 (d), will be to attempt recovery of the value of any benefits received in all situations, unless the beneficiary is judgment-proof. Systems used in collecting such payments are procedural in nature and will comply with all applicable laws and regulations.
- Comment:** There was no legislative review of the options for making changes in the appeals and grievances process, and to the extent that the proposed regulations make new policy choices not required by the Global Commitment waiver, we maintain that they are beyond the intent of the legislature when it approved the waiver.
- Response:** The proposed rules are required to be reviewed by the Legislative Committee on Administrative Rules. Furthermore, 33 V.S.A. § 1901 provides for the review of rules by the Health Access Oversight Committee, House Committee on Human Services and the Senate Committee on

Health and Welfare. Section 1901 also requires, at (d) that under Global Commitment OVHA serve as a publicly operated MCO and comply with the federal rules governing managed care organizations in Part 438 of Chapter IV of Title 42 of the United States Code.

**Comment:** Although the four sets of regulations cover many of the service decisions which will be made under the global commitment waiver, they fail to provide rules for appeals under the Traumatic Brain Injury (TBI) waiver administered by DAIL or appeals of mental health services overseen by the Department of Health.

**Response:** Because the mentioned programs are operated by DA/SSA's, they are, by definition, part of the MCO under Global Commitment and are therefore subject to the proposed rules. There is no need for those programs to individually issue their own grievance and appeal rules.

**Comment:** Rule 5 of the fair hearing rules promulgated by the Human Service Board in 1995 has a provision that requires the agency involved in appeal to review the agency decision.

**Response:** This is correct. The proposed rules are in harmony with Rule 5 and will standardize the process by which the agency's decisions are reviewed.

**Comment:** In many cases, the appellant will have difficulty attending a hearing that is not located at or close to his/her residence. This system does not meet the requirements of 42 C.F.R. 438.406(b)(2).

**Response:** 42 C.F.R. 438.406(b)(2) states that the process for appeals must provide the enrollee a reasonable opportunity to present evidence in person and in writing. As stated earlier, the rules are designed to oblige the schedules of the beneficiary, provider, and/or representative and allow them to attend the meeting where the appeal decision will be made. Every effort will be made to accommodate the parties involved. Should a party be unable to attend in person, they will be able to participate via telephone and/or representation by a third party. Commissioner reviews at DAIL enjoy continued success using these means of participation.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedules/schedule2.cfm> or call 828-5760.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

**Manual Holders:** Please maintain manuals assigned to you as follows.

**Manual Maintenance**

**Medicaid Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
TOC P.2 (M100)	(03-17)	TOC P.2 (M100)	(06-05)
nothing		TOC P.4 (M100)	(06-05)
M142	(91-01)	M142	(06-05)
M142.1 P.2	(03-17)	M142.1 P.2	(06-05)
M144	(88-21)	M143 P.2	(06-05)
nothing		M180	(06-05)
nothing		M180.1 P.2	(06-05)
nothing		M181	(06-05)
nothing		M181 P.2	(06-05)
nothing		M181 P.3	(06-05)
nothing		M181.1	(06-05)
nothing		M181.3	(06-05)
nothing		M181.3 P.2	(06-05)
nothing		M182	(06-05)
nothing		M184	(06-05)
nothing		M184.5 P.2	(06-05)

**VScript Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
3204.3 P.2	(05-09)	3204.3 P.2	(06-05)
3204.3 P.3	(03-17)	3204.5 P.2	(06-05)

**VHAP - Pharmacy Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
3302.6	(03-17)	3302.6	(06-05)
Nothing		3302.7	(06-05)

**Healthy Vermonters Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
3402.5	(03-17)	3402.5	(06-05)
3402.8 P.2	(03-17)	3402.8 P.2	(06-05)

**VPharm Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
3504.2	(05-24)	3504.2	(06-05)
3505	(06-18)	3504.4	(06-05)

**VHAP Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
4002.6	(03-17)	4002.6	(06-05)
nothing		4002.7	(06-05)

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M142

**M142**      Right to Appeal

Any Medicaid applicant or beneficiary has a right to appeal any decision about his or her Medicaid eligibility or amount of coverage, and to request a fair hearing before the Human Services Board (see Section M144) with the following exception: An applicant for or recipient of Supplemental Security Income (SSI/AABD) benefits who is denied SSI/AABD benefits or has his/her SSI/AABD benefits terminated because the Social Security Administration (SSA) or its agent found him/her to be not disabled, may not appeal the Medicaid denial or termination that results from this action by the SSA or its agent to the Human Services Board (see Disability Determination Appeal below).

Note: an applicant or beneficiary found to be not disabled by the SSA prior to 4/1/90 may appeal the resulting denial or termination to the Human Services Board as long as the appeal is filed within ninety (90) days of the date the notice of denial or termination was mailed. A person may also appeal if he or she thinks the Department is taking too long to make a decision. The right to appeal and procedures for making an appeal must be explained in Department forms and publications used by Medicaid applicants and beneficiaries and by Department employees during eligibility determination and review contacts.

Regarding eligibility issues, complaints or misunderstandings about decisions may be discussed with the employee who made the decision or his or her supervisor. If this review does not satisfy the applicant or beneficiary, he or she still has the right to request a fair hearing. A request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the Medicaid applicant or beneficiary wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (see M181) while a fair hearing is pending or before a fair hearing is requested (see M182). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

Medicaid beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at M184.

**M142.1**      Disability Determination Appeal

- (1) Social Security Administration (SSA) Disability Decision - except when the Department has made the disability determination (see below),
  - a final SSA disability determination is binding on the Department for 12 months or, if earlier, until the determination is changed by SSA and may not be appealed through the Department's appeal process. However, when an individual who has been found "not disabled" by the SSA meets the requirements specified in M211.4, he or she, though not entitled to an appeal of the SSA determination through the Department's appeal process,

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**M142.1**      Disability Determination Appeal (Continued)

is entitled to a separate state determination of disability for the purposes of determining his or her eligibility for Medicaid.

- the Department must refer all applicants who do not meet the requirements specified in M211.4 for a separate state determination of disability and who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability, to SSA for reconsideration or reopening of the determination.
- (2) Department Disability Decision - if the state's disability determination agent has made a Medicaid disability determination under the circumstances specified in Determination of Disability or Blindness, the decision may be appealed to the Human Services Board.

**M143**      Continued Benefits During Appeal or Fair Hearing

When beneficiaries appeal a decision to end or reduce Medicaid coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided or the fair hearing is resolved provided the beneficiary requests an appeal or fair hearing before the effective date of the adverse action and has paid in full any required premiums (see M181.3). If the last day before the adverse action date is on a weekend or holiday, the beneficiary has until the end of the first subsequent working day to request the appeal or fair hearing. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who are successful on an appeal concerning the amount of their premium will be reimbursed by the Department for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal or fair hearing is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

The OVHA may recover from the beneficiary the value of any continued benefits paid during the appeal and fair hearing period when the beneficiary withdraws the appeal or fair hearing before the relevant MCO or fair hearing decision is made, or following a final disposition of the matter in favor of the MCO. Beneficiary liability will occur only if an MCO appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCO also determines that the beneficiary should be held liable for service costs.

When SSI/AABD beneficiaries are determined "not disabled" by the Social Security Administration (SSA) and appeal this determination, their Medicaid coverage continues as long as their SSI/AABD benefits are continued (or could have been continued but the client chose not to receive them during the appeal period) pending a SSA decision on the appeal. When eligibility for SSI/AABD benefits is terminated following a determination of "not disabled", Medicaid coverage ends unless they apply and are found eligible for Medicaid on the basis of a categorical factor other than disability.

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M143      Continued Benefits During Appeal or Fair Hearing (Continued)

When Medicaid beneficiaries apply for SSI/AABD and are determined "not disabled" by the Social Security Administration (SSA) and file a timely appeal of this determination with the SSA, their Medicaid coverage continues until a final decision is made on the appeal provided the SSA's determination of "not disabled" is the only basis on which they might be found ineligible for Medicaid. If they continue to appeal unfavorable decisions by SSA, the "final decision" is made by the SSA Appeals Council.

M144      MCO Appeal and Fair Hearing Rules

Medicaid coverage appeals are processed in accordance with applicable MCO Appeals Rules, at M181, and fair hearing rules, as promulgated separately by the Human Services Board pursuant to 3 V.S.A. § 3091 (d). A copy of the Human Services Board fair hearing rules is in the All Programs Procedures Manual.

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M180

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**M180**      Global Commitment Appeals and Grievances

“Global Commitment” is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Office of Vermont Health Access, as a Managed Care Organization (“MCO”) under the Global Commitment 1115(a) waiver, is required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between beneficiaries and MCO employees, representatives of the MCO, and state designated agencies.

**M180.1**      Definitions

The following definitions shall apply for use in M180 through M184:

A. “Action” means an occurrence of one or more of the following by the MCO for which an internal MCO appeal may be requested:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the MCO provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

B. “Appeal” means a request for an internal review of an action by the MCO.

C. “Designated Agency/Specialized Service Agency” (“DA/SSA”) means an agency designated by the Department of Health or Department of Disabilities, Aging and Independent Living to provide services and/or service authorizations for eligible individuals with mental health or developmental disabilities.

D. “Designated Representative” means an individual, either appointed by an enrollee or authorized under State or other applicable law, to act on behalf of the beneficiary in obtaining a determination or in dealing with any of the levels of the appeal or grievance process. Unless otherwise stated in this rule, the designated representative has all of the rights and responsibilities of a beneficiary in obtaining a determination or in dealing with any of the levels of the appeals process.

E. “Expedited Appeal” means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

F. “Fair Hearing” means an appeal filed with the Human Services Board, whose procedures are specified in rules separate from the MCO grievance and appeal process.

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M180.1 Definitions (Continued)

- G. “Grievance” means an expression of dissatisfaction about any matter that is not an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.
- If a grievance is not acted upon within the timeframes specified in rule, the beneficiary may ask for an appeal under the definition above of an action as being “failure to act in a timely manner when required by state rule.”
- If a grievance is composed of a clear report of alleged physical harm or potential harm, the MCO will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services).
- H. “Managed Care Organization” (“MCO”) means:
1. the Office of Vermont Health Access (“OVHA”);
  2. any State department with which OVHA has an Intergovernmental Agreement under the Global Commitment 1115(a) waiver, excluding the Department of Education, that results in that department administering or providing services under the Global Commitment waiver (i.e. Department for Children and Families; Department of Disabilities, Aging and Independent Living; Department of Health, Division of Mental Health);
  3. a DA/SSA; and
  4. any contractor performing service authorizations or prior authorizations on behalf of the MCO.
- I. “Network” means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.
- J. “Provider” means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual’s medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.
- K. “Service” means a benefit 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (“CMS”), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Office of Vermont Health Access and Agency of Human Services Departments for the administration and operation of the Global Commitment to Health waiver.
- L. “Request for Reconsideration” means a process by which a beneficiary, provider or designated representative may request a review of an MCO decision by the individual or entity that made the original decision. A request for reconsideration is not considered an appeal.

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M181

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**M181**      Beneficiary Appeals**A.**      Right to Appeal

Beneficiaries may request an internal MCO appeal of an MCO action, and a fair hearing before the Human Services Board. A beneficiary may utilize the internal MCO appeal process while a fair hearing is pending or before a fair hearing is requested (see M182), except when a benefit is denied, reduced, or eliminated as mandated by federal or state law or rule, in which case the beneficiary cannot use the MCO appeal process and would challenge the decision only by requesting a fair hearing.

These rules should not be construed to preclude reconsideration of a decision by the MCO staff member or entity that made the original decision. A request for reconsideration may be made orally or in writing by the beneficiary, provider or designated representative. A request may be accompanied by any additional information that supplements or clarifies material that was previously submitted and is likely to materially affect the decision. A request for reconsideration does not suspend the time frame for filing an appeal or fair hearing.

**B.**      Request for Non-Covered Services

An MCO appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to OVHA under the provisions of the Medicaid rules at M108. A subsequent OVHA denial under M108 to cover such service cannot be appealed using the appeal process set forth in this rule, but may be appealed through the fair hearing process.

**C.**      Medicaid Eligibility and Premium Determinations

If a beneficiary files an MCO appeal regarding only a Medicaid eligibility or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (“DCF”), Economic Services Division. They will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the MCO appeal process and will be considered a request for fair hearing as of the date the MCO received it.

**D.**      Filing of Appeals

Beneficiaries may file appeals orally or in writing for any MCO action. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary’s request. Appeals of actions must be filed with the MCO within 90 days of the date of the MCO notice of action. The date of the appeal, if mailed, is the postmark date.

The MCO appeal process will include assistance by staff members of the MCO, as needed, to the beneficiary to initiate and participate in the appeal. Beneficiaries will not be subject to retribution or retaliation for appealing an MCO action.

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M181      Beneficiary Appeals (Continued)

E.      Written Acknowledgement

Written acknowledgement of the appeal shall be mailed within five calendar days of receipt by the part of the MCO that receives the appeal.

If a beneficiary files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct division within the MCO, identify the division to which it has been forwarded, and explain that the appeal will be addressed by that division. This does not extend the deadline by which appeals must be determined.

F.      Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the MCO in writing within five calendar days.

G.      Beneficiary Participation in Appeals

The beneficiary, designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which the MCO is considering the final decision regarding their appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

Upon request, the MCO shall provide the beneficiary or their designated representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The department will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

H.      MCO Appeals Reviewer

The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual that made the original decision. Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite clinical expertise, as determined by the state, in treating the beneficiary's condition or disease.

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M181 Beneficiary Appeals (Continued)I. Resolution

The beneficiary shall be notified as soon as the meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a scheduling or rescheduling results in exceeding the 45-day limit, an automatic 14-day time extension is effective. If a meeting cannot be scheduled within the 45-day time limit and 14-day extension, a decision will be rendered by the MCO without a meeting with the beneficiary, their designated representative, or treating provider.

Appeals shall be decided and written notice sent to the beneficiary within 45 days of receipt of the appeal. The 45-day period begins with the receipt of the appeal, and includes any review at the level of the DA/SSA. If an appeal cannot be resolved within 45 days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by the MCO if the extension is in the best interest of the beneficiary. If the extension is at the request of the MCO, it must give the beneficiary written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the MCO, is 59 days.

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M181.1

### M181.1 Expedited Appeal Requests

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the MCO for any MCO actions subject to appeal. The MCO will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

If the request for an expedited appeal does not meet the criteria and is denied, the MCO will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial for an expedited appeal must be promptly communicated to the beneficiary and followed up within two calendar days with a written notice.

If the expedited appeal request meets the criteria for such appeals, it must be resolved within three working days. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the beneficiary's right to request a fair hearing if not already requested.

### M181.2 Participating Provider Decisions

With the exception of a DA/SSA, provider decisions shall not be considered MCO actions and are not subject to appeal using this process. A state agency shall be considered a provider if it provides a service that is:

1. Claimed at the Medicaid service matching rate;
2. Based on medical or clinical necessity; and
3. Not prior authorized.

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M181.3

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**M181.3**      Notices, Continuation of Services, Beneficiary Liability for Service Costs**A.**      Beneficiary Notice

The division of the MCO issuing a services decision must provide the beneficiary with written notice of its decision. In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least eleven (11) days before the change will take effect. Where the division's decision was adverse to the beneficiary, the notice must inform the beneficiary when and how to file an appeal or fair hearing. In addition, the notice must inform the beneficiary that he or she may request that covered services be continued without change as well as the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any MCO appeal or fair hearing.

**B.**      Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered health service termination or reduction under the following circumstances:
  - a. The MCO appeal was filed in a timely manner, meaning before the effective date of the proposed action;
  - b. The beneficiary has paid any required premiums in full;
  - c. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and
  - d. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.
2. Where properly requested, a service must be continued until any one of the following occurs:
  - a. The beneficiary withdraws the appeal;
  - b. Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
  - c. The MCO issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;
  - d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or
  - e. The original service period ordered by an authorized provider has expired.

Beneficiaries may waive their right to receive continued benefits pending appeal.

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Bulletin No. 06-05

M181.3 P.2

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M181.3      Notices, Continuation of Services, Beneficiary Liability for Service Costs (Continued)

C.      Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

D.      Beneficiary Liability for Cost of Services

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

The MCO may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant MCO or fair hearing decision is made, or following a final disposition of the matter in favor of the MCO. Beneficiary liability will occur only if an MCO appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCO also determines that the beneficiary should be held liable for service costs.

If the provider notifies the beneficiary that a service may not be covered by Medicaid, the beneficiary can agree to assume financial responsibility for the service. If the provider fails to inform the beneficiary that a service may not be covered by Medicaid, the beneficiary is not liable for payment. Benefits will be paid retroactively for beneficiaries who assume financial responsibility for a service and who are successful on such service coverage appeal.

E.      Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the MCO is not required to initiate service delivery.

The MCO is not required to provide a new service or a health service that is not a Medicaid-covered service while a fair hearing determination is pending.

7/1/07

Bulletin No. 06-05

M182

**M182**      Fair Hearing

A beneficiary may utilize the MCO appeal process and be entitled to a fair hearing before the Human Services Board. Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed. If the beneficiary's original request for an MCO appeal was filed before the effective date of the adverse action and the beneficiary has paid in full any required premiums, the beneficiary's services will continue consistent with M181.3 B.

MCO beneficiaries have the right to file requests for fair hearings related to eligibility and premium determinations. DCF shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations.

**M183**      School-Based Health Services

The State uses the School-Based Health Services Program to obtain Medicaid reimbursement for medical services provided by schools to eligible students. To be eligible, the students must be enrolled in Medicaid, receiving special education services, and receiving Medicaid-billable services. School districts can claim reimbursement under the Program only for those students on an individualized education program ("IEP") and not for students on 504 plans. A release of protected health information for each eligible student is required before any claims can be processed. The parent or guardian has the right to refuse to give consent to such a release. In such case, the school district cannot claim Medicaid reimbursement for any services provided to that student. Additionally, a physician or a nurse practitioner must sign a physician authorization form, establishing that the IEP services are medically necessary.

Federal Individuals with Disabilities Education Improvement Act ("IDEA") statutes and regulations govern the process for assessing needs and developing the IEP. Separate Department of Education due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child's identification, eligibility, evaluation, IEP or placement have three options available under the DOE procedures for resolving disputes with the school: mediation, a due process hearing and/or an administrative complaint. The Department of Education due process and appeals procedures also apply to Global Commitment services authorized under Part C of IDEA.

7/1/07

Bulletin No. 06-05

M184

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M184      Beneficiary Grievances

M184.1      Filing Grievances

A grievance may be expressed orally or in writing. A grievance must include a clear statement by the beneficiary that a written response is requested from the MCO. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

M184.2      Written Acknowledgement

Written acknowledgement of the grievance must be mailed within five calendar days of receipt by the MCO. The acknowledgement must be made by the part of the MCO responsible for the service area that is the subject of the grievance. If the MCO decides the issue within the five day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.

M184.3      Withdrawal of Grievances

Beneficiaries or designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the MCO in writing within five calendar days.

M184.4      Disposition

All grievances shall be addressed within 90 calendar days of receipt. The decision maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with the MCO as well as information on how to initiate such review.

M184.5      MCO Grievance Review

A.      Initiating a Grievance Review

If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the MCO within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

B.      Written Acknowledgement

The MCO will acknowledge grievance review requests within five calendar days of receipt.

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Bulletin No. 06-05

M184.5 P.2

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M184.5      MCO Grievance Review (Continued)C.      Disposition

The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review.

Although the disposition of a grievance may not be appealed to the Human Services Board, the beneficiary may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V.S.A. §3091 (a).

M184.6      MCO Components with Responsibility for Addressing Grievances

The MCO and any part of the MCO receiving funds for the provision of services under the Global Commitment to Health shall be responsible for resolving grievances initiated under these rules.

7/1/07

Bulletin No. 06-05

3204.3 P.2

### 3204.3 Period of Eligibility and Enrollment

#### B. Enrollment (Continued)

If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in section M150.1(A)(1), the beneficiary or their representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. The Department will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The beneficiary is responsible for all bills incurred during the period of non-coverage until the Department receives the required verification and premium amounts due.

If the medical incapacity is expected to continue or recur, the Department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition (see Rule M104).

### 3204.4 Payment Methodology

Participating pharmacies shall dispense a drug upon verification of a beneficiary's enrollment. The pharmacy shall collect the charge for the drug from the Department.

### 3204.5 Right to Appeal

Regarding eligibility issues, a request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Individuals who have applied for or received VScript may appeal any decision of the Office of Vermont Health Access ("OVHA") relating to their coverage and may request an internal managed care organization ("MCO") appeal and a fair hearing before the Human Services Board. A beneficiary may utilize the internal MCO appeal process (see M181) while a fair hearing is pending or before a fair hearing is requested (see M182). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VScript coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid in full any required premiums (see M181.3). Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved.

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Bulletin No. 06-05

3204.5 P.2

3204.5 Right to Appeal (Continued)

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141). Beneficiaries who waive their right to continued benefits will be reimbursed for out-of-pocket expenses for covered services provided during the appeal process in any case in which the MCO or Human Services Board reverses the decision.

VScript beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at M184.

Notice of an adverse change in cost sharing requirements must be mailed to individuals at least 10 days before the effective date.

7/1/07

Bulletin No. 06-05

3302.6

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**3302.6**      Right to Appeal

The Department shall provide individuals with notice whenever they are found ineligible for the VHAP-Pharmacy program or when the services they may receive under the VHAP-Pharmacy program are denied, reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request an internal managed care organization ("MCO") appeal and a fair hearing before the Human Services Board.

Regarding eligibility issues, a request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (see M181) while a fair hearing is pending or before a fair hearing is requested (see M182). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VHAP-Pharmacy coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid in full any required premiums (see M181.3). Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who appeal the amount of their premium and win will be reimbursed by ESD for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141). Beneficiaries who waive their right to continued benefits will be reimbursed for out-of-pocket expenses for covered services provided during the appeal period in any case in which the MCO or Human Services Board reverses the decision.

VHAP-Pharmacy beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at M184.

7/1/07

Bulletin No. 06-05

3302.7

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3302.7      Beneficiary Fraud Investigation

A person, who knowingly gives false or misleading information or holds back needed information in order to obtain VHAP-Pharmacy benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When ESD learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the beneficiary. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

7/1/07

Bulletin No. 06-05

3402.5

3402 Eligibility Process3402.5 Requirement to Report Changes

Applicants and beneficiaries must report changes in income and household composition within 10 days after learning of the change. They must also notify the Department within 10 days after they:

- become eligible for insurance or other assistance covering prescription drugs;
- no longer meet state residency requirements (3401.3);
- are incarcerated; or
- have a change of address.

3402.6 Identification Document

The Department shall provide each eligible Healthy Vermonters individual with an identification card. This identification card may be used only at participating pharmacies as defined at 3403.5.

3402.7 Application for Other Benefits

Individuals accepted into the Healthy Vermonters program may apply for the traditional Medicaid program or any other health care program at any time.

Individuals who wish to apply for traditional Medicaid or other benefits available through the Department must file an application as required under those programs.

3402.8 Right to Appeal

The Department will provide applicants and beneficiaries with notices whenever they are found ineligible for the Healthy Vermonters program or when the services they may receive under the Healthy Vermonters program are denied, reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request an internal managed care organization ("MCO") appeal and a fair hearing before the Human Services Board. Appeals regarding denials of eligibility will not be entitled to an internal MCO appeal.

Regarding eligibility issues, a request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (see M181) while a fair hearing is pending or before a fair hearing is requested (see M182). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

7/1/07

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3402.8 P.2

3402 Eligibility Process3402.8 Right to Appeal (Continued)

When beneficiaries appeal a decision to end Healthy Vermonters coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries who waive their right to continued benefits will be reimbursed for out-of-pocket expenses for covered services provided during the appeal period in any case in which the Human Services Board reverses the decision.

3402.9 Beneficiary Fraud Investigation

A person who knowingly gives false or misleading information or holds back needed information in order to obtain Healthy Vermonters benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When the ESD learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the beneficiary. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

7/1/07

Bulletin No. 06-05

3504.2

### 3504.2 Identification Document

Each individual in the household enrolled in VPharm is provided with an identification card which includes the individual's name and identification number.

### 3504.3 Notice and Right to Appeal

ESD shall provide individuals with notice whenever they are found ineligible for the VPharm program or when the coverage they may receive under the VPharm program is denied, reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request an internal managed care organization ("MCO") appeal and a fair hearing before the Human Services Board. Appeals regarding denials of eligibility will not be entitled to an internal MCO appeal.

Regarding eligibility issues, a request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (see M181) while a fair hearing is pending or before a fair hearing is requested (see M182). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VPharm coverage, they have the right to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid and continues to pay any required premiums in full (see M181.3). Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who successfully appeal the amount of their premium will be reimbursed by ESD for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141 of the state Medicaid rules).

Beneficiaries who waive their right to continued benefits will be reimbursed for out-of-pocket expenses for covered services provided during the appeal period in any case in which the MCO or Human Services Board reverses the decision.

VPharm beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115(a) waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at M184.

7/1/07

Bulletin No. 06-05

3504.4

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3504.4      Beneficiary Fraud Investigation

A person who knowingly gives false or misleading information or holds back needed information in order to obtain VPharm benefits, may be prosecuted for fraud under Vermont law or federal law or both; if convicted, the individual may be fined or imprisoned or both.

When ESD learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the beneficiary. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

7/1/07

Bulletin No. 06-05

4002.6

4002 Eligibility Process4002.6 Right to Appeal

Applicants and beneficiaries shall be provided by the department with notices whenever an individual is found ineligible for the VHAP program or when the services they may receive under the VHAP program are denied, reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request an internal managed care organization ("MCO") appeal and a fair hearing before the Human Services Board. Appeals regarding denials of eligibility will not be entitled to an internal MCO appeal.

Regarding eligibility issues, a request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (see M181) while a fair hearing is pending or before a fair hearing is requested (see M182). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VHAP coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid in full any required premiums (see M181.3). Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who appeal the amount of their premium and win will be reimbursed by the ESD for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries who request a hearing after the effective date of termination will not receive continued benefits but will be reimbursed for out-of-pocket expenses provided during the appeal period in any case in which the MCO or Human Services Board reverses the decision.

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

VHAP beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at M184.

See 4003.22 for rights to appeal managed health care decisions or disenrollment from a plan.

7/1/07

Bulletin No. 06-05

4002.7

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4002.7      Beneficiary Fraud

An individual who knowingly gives false or misleading information or holds back needed information to obtain VHAP benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When ESD learns that fraud may have been committed, it will investigate the case with respect to confidentiality and the legal rights of the recipient. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.